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FISCAL IMPACT STATEMENT

LS 7108
BILL NUMBER: HB 1325

NOTE PREPARED: Feb 2, 2010
BILL AMENDED: Feb 1, 2010

SUBJECT: Long-Term Care Services.

FIRST AUTHOR: Rep. Crouch
FIRST SPONSOR: Sen. Becker

BILL STATUS: As Passed House

FUNDS AFFECTED: X GENERAL
X DEDICATED
X FEDERAL

IMPACT: State

Summary of Legislation: This bill provides that all provisions included in the bill are subject to the availability of funding for the Office of the Secretary of Family and Social Services (FSSA).

Distribution of AAA Funding: The bill specifies the amount and the manner in which the state is to complete the allotment process and distribute funds to the Area Agencies on Aging (AAAs) for the provision of home and community-based services. It also requires the FSSA to make certain calculations of savings, use the calculated savings, and ensure that costs for services do not exceed funding available.

The bill also provides the AAAs with flexibility in the management of certain program funding, and prohibits the Division of Aging (DOA) from imposing restrictions that are not in the DOA's contract with a AAA.

The bill allows spouses and parents of individuals who are at risk of being institutionalized to provide attendant care services, and limits the amount of services that can be reimbursed.

The bill also requires the dissemination of specified information as part of: (1) a nursing facility's notification to applicants; (2) the nursing facility preadmission screening program; and (3) the hospital discharge process.

Provider Registry and Other Services: The bill requires the DOA to establish a provider network and a program and standards for providers of home and community-based services for persons in the CHOICE program.

Presumptive Eligibility: The bill also allows a AAA to make presumptive eligibility determinations for the Aged and Disabled (A&D) Medicaid waiver under specified circumstances.

Effective Date: July 1, 2010.

Explanation of State Expenditures: *Summary:* The bill provides that all provisions are subject to the availability of funding.

Distribution of AAA Funds: This provision would result in the state losing General Fund interest income or paying financing costs for the AAAs.

Required Savings Calculations and Uses: It is unclear at this time how the provision would interface with General Fund appropriation and reversion requirements.

Presumptive Eligibility (PE) Administrative Expense: FSSA has estimated that administrative expenses of $1.2 M would be required to implement the PE provision in the bill.

Presumptive Eligibility Program Expense: Depending upon administrative actions, the state-operated PE provision could cost as much as $7.0 M. However, if sufficient resources are already in place to expedite the entire waiver eligibility process, the cost could be as low as $763,000. Savings that would be realized under the provisions of this bill would be related to the number of Medicaid nursing home admissions that would be prevented by the provision of home and community-based care services.

Provider Registry and Other Services: These provisions require the Division on Aging to act as a statewide coordinating service for providers and consumers of self-directed care. The cost of the required services is not known at this time. However, FSSA anticipates information system upgrades and additional staffing would be necessary.

Additional Information:

Distribution of AAA funds: The bill would require that all funding from state and federal sources be disbursed to the AAAs in two equal installments; the first on the first business day of a fiscal year and the second on the first business day of the third quarter of a fiscal year. This provision would require the state to transfer approximately $36.7 M in state funds to the AAAs twice each year for a total of $73.35 M. The money would be held in the AAA's bank accounts until expended by the agencies. The state would be required to advance state funds until such time as the AAAs would document the obligation of the federal funds, at which time the state would be reimbursed from federal funds. The state would also forego any interest earned on the state funds advanced. The bill further provides that should the state fail to distribute the funds in the prescribed manner, any financing costs paid by a AAA as a result are to be reimbursed by the state.

Savings Calculations and Uses: The bill also requires FSSA, in consultation with the AAAs, to calculate the savings in each state fiscal year that result from the provision of home and community-based services as compared to nursing facility services. FSSA is required to use the calculated savings amount to purchase home and community-based services for additional individuals. This cost estimate would require an estimate of how many individuals would have been institutionalized without the provisions of the bill. It is not clear how this use of savings generated in one year would interface with the annual appropriation since General Fund appropriations that remain unobligated revert to the General Fund at year end and are not available for expenditure in a subsequent year unless specified by the General Assembly.

Presumptive Eligibility: The bill would establish a state-funded presumptive eligibility program for Medicaid

Aged & Disabled (A&D) waiver applicants. The bill would allow the Area Agencies on Aging to make a determination that an applicant, who is at risk of being institutionalized if immediate long-term care services are not received, is presumptively eligible for a defined number of Medicaid A&D waiver services if a Medicaid application has been completed and the AAA has determined the applicant is deficient in at least three activities of daily living. The AAA's determination of presumptive eligibility would allow for the immediate provision of the allowable services needed by the applicant. The bill provides that the AAAs would have the flexibility to determine how services would be funded until such time as the applicant is determined to be eligible for the Medicaid A&D waiver. Services provided under the A&D waiver include home and community-based services, assisted living, and adult foster care.

The cost of this provision is associated with the number of waiver slots available; if there are no waiver slots available there should be no expenses incurred. This would also eliminate any potential for Medicaid savings from the diversion of individuals from more expensive nursing facility placements. Cost is also associated with the number of persons that might be determined to be presumptively eligible, the point in time that federal reimbursement would become available for waiver recipients, the expense of services provided to persons subsequently found to be ineligible for Medicaid, and with the associated state administrative expense. Presumably, any services provided that are not eligible for Medicaid reimbursement would be funded by the CHOICE state appropriation or other state and federally funded programs operated by the AAAs.

FSSA reports that about 4,800 applications for A&D waiver services are received annually. Based on the experience in Ohio, about 55% of these applications might be eligible for the PE process, resulting in about 2,640 individuals that might be started on services after an initial assessment as provided in the bill. FSSA reports that federal matching funds are not available for waiver services until a care plan is approved. As of June 2009, AAAs on average were taking 44 days to submit care plans to DOA for approval and DOA required 6 days to approve the plans. This was a total of 50 days required to get to the point where federal matching funds would be available. Waiver services cost approximately $49.80 per day in 2009. If no changes were made to the system, approximately $6,573,600 in 100% state-dollar expenditures would be required to fund services provided within the 50-day period of time. If services were authorized for a total of 90 days, and an initial 8% PE error rate is assumed (as experienced in a Kansas pilot program), another $420,000 might be incurred for services for individuals subsequently found to be ineligible.

A total of approximately $7.0 M would be required for this program if no changes are made to expedite the process as is done in other states. With expedited care plans and an expedited Medicaid application process, other states are making decisions in as little as 2 to 4 days. If PE is used, the error rates are below 2%. Depending on administrative action, if the care plans could be developed and approved in 5 days, and the PE error rate were as high as 2%, the program could cost $763,000 to provide the services. The level of resources used in other states to achieve the necessary actions and how they compare to the level of resources currently available in Indiana is not known at this time.

Flexibility of Service Funding by AAAs: The bill would require FSSA to refrain from imposing any restrictions on a AAA other than those required under the terms of the contract with the AAA. This would allow the 16 AAAs to manage funds among 14 separate programs with increased flexibility. This provision would presumably allow the AAAs to use CHOICE or other appropriate funds to provide funding to pay for services provided under PE determinations that are later determined to be ineligible for Medicaid A&D waiver services.

FSSA is the single state agency that is accountable to the federal government for the expenditure of federal

dollars under several of the programs. This provision would require the agency to turn over responsibility for the expenditure of funds to 16 AAAs after the contracts with FSSA are executed. The cost of this provision would depend on administrative actions; FSSA could write the terms of the contracts to provide for more administrative control. This could increase administrative expense as contract amendments would be a method for maintaining accountability.

A&D Waiver Considerations: The bill does not require additional waiver slots be made available. If no waiver slots are available and individuals are placed on a waiting list, there should be no expenses associated with the provision of services. Any potential for Medicaid savings to be achieved by diverting nursing home admissions to less expensive A&D waiver services would also be eliminated. FSSA reported that 463 Medicaid applicants were added to the A&D waiver waiting list in the month since the available 10,409 waiver slots were filled December 3, 2009. FSSA also reported that an additional 1,000 waiver slots are budgeted to open at the beginning of FY 2011and FY 2012. If PE is in place when the slots become available, the resources necessary to process care plans and Medicaid applications on a timely basis may be overwhelmed potentially increasing state dollars needed to provide services.

The presumptive eligibility provision would have to be closely tracked by FSSA to ensure that PE and services are not provided to more individuals than there are available waiver slots. This is especially important since waiver slots must be demonstrated to be fiscally neutral to the federal government, and Medicaid waiver clients would also be eligible for full State Plan services during the look-back period to the approval of the care plan. FSSA reports State Plan services cost about $34 per day for waiver clients. Depending on the range of error rates experienced with an initial implementation, State Plan services provided to individuals subsequently found not to be Medicaid eligible could be in a range of $72,000 to $287,000. The expense would be contingent on the prudent use of the option by the AAAs.

The Indiana Medicaid appropriation provides a single open-ended dollar amount for all services provided under the program. While the Office of Medicaid Policy and Planning (OMPP) may have targeted amounts for expenditure classifications such as nursing facilities, hospitals, and waiver services, OMPP has the flexibility within the single appropriation to reallocate funds between expenditure classifications as necessary.

Savings in one area of the program can be applied to expenditures in another area internally within the budgeted appropriation. Any savings under the provisions of this bill would be related to the number of Medicaid nursing home admissions that would be prevented by the provision of home and community-based care services. Any savings that may result from fewer nursing facility admissions than originally projected may or may not be available to expand services in the waivers. If the number of eligible participants entitled to Medicaid State Plan services expands above the projected levels in other eligibility categories, funding freed up by savings may be needed to provide entitlement services.

Rule Promulgation: The bill would require FSSA to promulgate two sets of rules: the first, to determine a list of home and community-based services that could be provided to Medicaid applicants determined to be presumptively eligible for A&D waiver services; and the second, to provide for the provision of compensation for attendant care services provided by the parent of a minor child or a spouse. Rule promulgation is considered to be a routine administrative function that should be able to be provided within the level of resources available to the agency

PE Administrative Expense: FSSA reports that Medicaid information technology system requirements and training expenses to implement a presumptive eligibility option would require $1.2 M. This estimate is based

on the cost of implementing PE for pregnant women. The AAAs are not mandated to make PE determinations by the bill. The level of resources required for the AAAs to perform the PE is not known at this time. If additional resources would be needed to expedite the process, FSSA does not have resources to provide additional funding for the AAA contracts without cutting some other existing service.

Provider Registry, Training and Certification, and Hotline Requirements: FSSA is required to create and maintain a statewide registry of home and community-based providers who have been trained and certified by the Division on Aging and make the list available to AAAs. The bill also requires FSSA to perform fiscal intermediary services within the agency. (Currently, FSSA has a contractor for this function.) [The expenditure related to the contract will be reported when the information is available from FSSA.] The bill also requires a statewide hotline and support services to address self-directed care emergencies and other needs of consumers who choose to self-direct their care. These provisions require the Division on Aging to act as a statewide coordinating service for providers and consumers of self-directed care. The cost of the required services is not known at this time. FSSA reports that staffing system enhancements would be necessary to produce and maintain the required registry. Current training and certification activities include a one-year expense of $180,000 for curriculum development and training for 100 home care workers. Ongoing training expenses are anticipated to be $60,000 annually.

Compensation for Personal Attendant Services: The bill allows for parents of dependent children and spouses to receive compensation for personal attendant services provided for no more than 40 hours a week under rules to be promulgated by FSSA. This provision should be budget neutral since the individuals eligible for the services could have them provided by any provider. Attendant services included in the individual's care plan are limited to the hours of care needed. This provision would allow a close family member to receive compensation under circumstances defined by FSSA.

Distribution of Required Information: The bill requires AAAs, nursing facilities, and hospitals to give AAA contact information and information on local long-term care services options available to individuals. The bill requires OMPP to prepare the list of available local services. It is unclear if this would be a service covered under the AAA contracts or if OMPP would need to provide compensation to have the specific lists developed. AAAs are required to provide this information within seven days of a person's admission to a nursing facility. It is not known at this time if the 16 AAAs have sufficient staffing resources to accomplish this requirement without additional funding.

Hospital Requirements: The bill specifies that hospitals must identify long-term care facilities on the list of local service options in which the hospital, members of its medical staff, governing board, or executive staff has any financial interest. The bill provides that a patient may not be discharged to such a facility unless consent has been given. The bill allows FSSA to charge a hospital with the costs that are incurred by the state and the patient to correct a placement made under this situation. The cost of this provision would depend on individual circumstances. FSSA may need to promulgate rules to define a recovery process.

Background Information-

Presumptive Eligibility Background Information: Federal Medicaid matching funds are available for services provided during a period of presumptive eligibility for home and community-based services that are State Plan services - but not for waiver services. For example, Indiana has PE for State Plan services for pregnant women. If a woman receives pregnancy-related services during a PE period and is later determined to be ineligible for Medicaid, the federal matching rate is still available to reimburse for those services. Because

the home and community-based services provided under the A&D waiver are not State Plan services, any services provided during a PE period for a person who is found to be ineligible for Medicaid would not be eligible for reimbursement under the Medicaid program - those expenses would need to be reimbursed using all state dollars or recovered from the applicant.

Once a determination of eligibility has been made, Medicaid regulations provide for a three-month look-back period. Any waiver services and State Medicaid Plan services provided during the look-back period are reimburseable under the Medicaid program and eligible for federal matching funds. In order to receive reimbursement for Medicaid waiver services an approved care plan must be in place. Nursing facilities currently may decide to admit a patient under the assumption that they will be determined to be Medicaid-eligible; however, the nursing facility takes the risk that later they might have to try to collect reimbursement from the patient if the patient is subsequently determined to be ineligible for Medicaid. Consequently, the cost associated with this provision is related to the expense of services provided to persons subsequently found to be ineligible for Medicaid, and with the associated administrative expense.

[FSSA is currently inquiring of CMS if a waiver for PE for the A&D waiver is a possible option for the state. This information will be updated when FSSA receives an answer.]

CHOICE Funding Background Information: The PE provision assumes that CHOICE funding or some other source of funding is available to provide services to persons subsequently determined to be ineligible for Medicaid. The annual appropriation for CHOICE is $48.8 M for each year of the budget biennium. Of the total appropriation, up to $12.9 M may be transferred each year to Medicaid to provide state matching funds for the A&D waiver, leaving a minimum of $35.9 M available for CHOICE services. The account disbursed 32.0 M for services in FY 2009 and appears to be spending at a slightly faster rate than in previous years. The dedicated CHOICE appropriation is nonreverting; $4.77 M was rolled over to the fund at the end of FY 2009.

FSSA reports that the CHOICE program had 2,161 individuals waiting for services as of January 4, 2010. Depending on the number and accuracy of the presumptive eligibility determinations made by the 16 AAAs, the CHOICE appropriation may not have sufficient funds to provide for temporary limited services to individuals found to be ineligible for A& D waiver services. With PE, the program could not consider extending services to individuals on the waiting list.

Explanation of State Revenues:

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: FSSA, OMPP and the DOA.

Local Agencies Affected:

Information Sources: FSSA. "Expediting Medicaid Financial Eligibility" Robert L. Mollica, National Academy for State Health Policy, July 2004.

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